What You Need to Know About Medicare

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Medicare Secondary Payer Act

- Medicare Secondary Payer Act (MSPA) enacted in 1980
- Relegated Medicare to "secondary" payer status when any other entity could *possibly* be considered a primary payer
- Statute applies to workers' compensation, automobile or liability insurance, no-fault insurance and self-insurers

- MSPA and corresponding Regulations have been amended and expanded several times.
- When Federal Courts have tried to deny or limit Medicare's rights, Congress has subsequently amended the MSPA to remedy the effect of those cases.
- Clear Congressional intent is to ensure that Medicare pays *secondarily* to the maximum extent possible.

Two Issues to Consider

- Conditional Payment Claims
- Medicare Set-asides

Conditional Payment Claims

- Conditional payment claims (CPC) are **NOT** the same as Medicare Set-asides.
- CPC is asserted by Medicare for expenses it paid ***prior to*** date of settlement or judgment
- Medicare Set-asides are designed to pay medical expenses ***after*** date of settlement

- CPC arises when Medicare exercises its option to pay medical expenses for a Medicare beneficiary then seeks reimbursement from primary payer.
- CPC issues are the same in workers' compensation and liability cases.

Medicare's Right to Recover

- Federal law takes precedence over any state law or private contract.
- That means Medicare's right to recover may not be limited by a state law or a settlement agreement between parties.
- Medicare's right to recover is always paramount to ***any*** other entity or individual's rights.

Duty to Notify Medicare of Primary Payer Situation

- To assist Medicare with recovery of CPCs, the law imposes obligation to notify Medicare of primary payer situations.

2009 Notification Requirements

- Beginning October 1, 2009, “liability insurance including self insurance, no-fault insurance and workers’ compensation laws and plans” must begin submiting information to Medicare concerning ALL CLAIMS involving a Medicare beneficiary.
- Includes extensive information about the claimant, the claim, and the potential primary payer.

When to Notify Medicare

- CMS issued compliance timeline in September 15, 2008:
- January 1, 2009 - June 30, 2009 - Recommended systems development period
- May 1, 2008 - June 30, 2009 Electronic registration via the Coordination of Benefits Secure Web site for all liability/no-fault/workers' compensation Responsible Reporting Entities .
- July 1, 2009 - September 30, 2009 Testing period for all liability/no-fault/workers' compensation Responsible Reporting Entities
- October 1, 2009 - December 31, 2009 All liability/no-fault/workers' compensation RREs submit their first Section 111 production files based upon a predetermined schedule with the Coordination of Benefits Contractor
- January 1, 2010 All liability/no-fault/workers' compensation Responsible Reporting Entities will be submitting Section 111 production files by this date

- Some confusion over this issue
- One phrase provides that an “applicable plan shall determine whether a claimant (including an individual whose claim is *unresolved*)” is a beneficiary and must notify Medicare.
- Thereafter, the law states that the information must be provided to Medicare *after* the claim *is resolved* through settlement judgment, award or other payment

- It appears from the supporting statement issued by CMS that in cases in which no money is paid on the claim **at all** until the time of settlement, insurers will only be required to report information at the time of settlement, judgment, award or other payment.
- For claims in which at least one payment has been made to the claimant or on behalf of the claimant those must be reported to CMS right away.
  - Thereafter, insurers are under an obligation to update the information with CMS quarterly throughout the duration of the claim.
- Further clarification of the timing has been requested.

Penalties for Failure to Comply

- Plans failing to provide notification to Medicare are subject to civil penalty of $1,000.00 per day, per claimant
- There are no safe harbors. All plans are expected to comply.

Ensuring Compliance with New Law

- Immediately upon receiving ANY claim, ask if claimant is a Medicare beneficiary or Social Security Disability recipient and confirm again before settlement. Also consider the claimant's age.
- In litigated cases, defense attorneys should ALWAYS ask the claimant's status during discovery and confirm again before settlement
- Claimant's attorneys should always ask the client's status upon accepting representation and confirm again before settlement

- 2009 Notification Requirements will ensure Medicare does not pay when another entity is, even arguably, responsible
- Will also enable Medicare to more easily recover conditional payments from primary payers
- Expected to save Medicare over $1 billion between 2008 and 2017

Medicare's Recovery of CPCs

- When ***any*** case with a Medicare beneficiary settles, if Medicare has made a CPC, Medicare must be reimbursed.
- Therefore, *prior to settlement* CPC research should be conducted for ALL injuries included in settlement.
- Obtaining CPC information can take a few months.
- May dispute CPC in some cases if treatment is undisputedly, totally unrelated.
- ***Final*** CPC letter will not be issued until Medicare receives copy of approved settlement documents.
- Payment only due at this time.

- If Medicare is not reimbursed for its CPC, it may assert a direct cause of action against “a primary payer, a beneficiary, provider, supplier, physician, attorney, State Agency, or private insurer that has received a primary payment.”

- When more than one entity is potentially responsible, Medicare retains the right to assert claims against all of them
- In addition to direct cause of action, Medicare has subrogation and intervention rights

Obligations if Payment for CPC Already Made to Individual or Other Entity

- If primary payer has paid a claimant money in a settlement with the intention that the claimant resolve the CPC, if Medicare is not actually reimbursed, the primary payer will have to repay Medicare *even though it has already paid the beneficiary for those expenses*
- Therefore, it is NOT wise to do nothing more than include language in settlement documents stating that claimant will reimburse Medicare

Amount CMS May Recover

- CPC may be reduced for procurement costs
- Medicare may recover **FULL** amount of CPC up to total settlement amount ***even if claimant only recovered a portion of what would otherwise be due if the claim had not settled!***
  - Claimant could end up with nothing!
- Medicare may waive or reduce its recovery in certain circumstances, but it is very limited.
  - Only available to beneficiaries, not insurance companies trying to reduce amount due

Interest and Penalties Under the MSPA

- If Medicare is not reimbursed within 60 days from the date of final demand letter, interest will begin to accrue
  - Payment not due until final demand letter is sent by Medicare
- If Medicare has to file a lawsuit to recover its money, it will collect double damages from whomever it sues

Private Cause of Action

- MSPA provides for private cause of action
  - May be asserted by Medicare beneficiary when
    - primary payer fails to pay medical expenses when it is obligated to do so and
    - Medicare pays for medical expenses instead

Statute of Limitations for Medicare to Assert Claim

- 6 years
- Begins to run once "facts material to the right of action are known or reasonably could be known" by the U.S.
  - Arguably, could even be after Medicare makes payment.

Challenging Medicare's Claim

- In order to challenge a CPC or any other claim, must exhaust administrative remedies!
- Medicare may NEVER be sued by any party for any reason in connection with the Medicare Act without first going through administrative remedy process.
  - Once administrative remedies have been exhausted, judicial review may be requested, but it is limited.
- Medicare may NEVER be made a party to any state or federal action without its consent.

Medicare Set-asides

Medicare Set-asides

- Medicare Set-aside (MSA) is money for future medical expenses related to a specific accident or injury
- Neither MSPA nor any other legislation makes MSAs an *absolute requirement* in any case.
- MSAs are the best and perhaps only way to show that Medicare's interests were adequately considered/protected at time of settlement
- CMS recommends MSAs in workers' compensation cases with Medicare beneficiaries when future medical benefits are closed

- If Medicare's interests are not adequately considered, Medicare may require exhaustion of entire settlement amount on medical expenses before it begins paying for any treatment for the claimant related to the injury at issue
- Medicare may also pay medical expenses and request reimbursement

MSAs in Workers' Compensation Cases

- CLASS I
  - If the claimant is a Medicare beneficiary AND
  - the total settlement amount exceeds $25,000,
- CMS approval of a MSA should be obtained.

- CLASS II
  - If the total settlement amount is greater than $250,000 AND
  - the claimant has “a reasonable expectation” of becoming a Medicare beneficiary within 30 months of the settlement
  - CMS approval of a MSA should be obtained.

Determining The Total Settlement Amount

- Money paid at time of settlement for future medical expenses, including prescription medications
  - If using structure, must include *uncommuted* expected lifetime payout
- Money paid at time of settlement for indemnity and vocational benefits
- Claimant's attorney fees
- Court costs and filing fees
- Medicare CPC, if any
- Money paid in prior partial settlement, if any

Reasonable Expectation of Entitlement

- If the claimant:
  - Is currently receiving Social Security Disability (SSD) benefits
  - Has applied for SSD benefits
  - Was denied SSD benefits, but is appealing denial
  - Is 62.5 years old or older
  - Has End Stage Renal disease

Cases That do not Meet CMS Review Thresholds

- Medicare beneficiaries
  - Medicare beneficiaries must always consider and protect Medicare's interests when settling claims regardless of settlement amount
- No safe harbor

- For ***Medicare beneficiaries***, CMS stated:
  - "In other words if the total settlement amount is ***$25,000.00 or less***, the parties to the settlement are still required to consider Medicare's interests. The ***recommended method to protect Medicare's interest is to enter into a Medicare Set Aside arrangement*** to protect Medicare's interest even though CMS will not review the proposal." (http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wsetaside.asp citing CMS Memo July 11, 2005 (last viewed June 5, 2008)).

Cases Not Meeting CMS Review Threshold
Non-Medicare Beneficiaries

- CMS stated:
  - "when a non-Medicare eligible claimant's [workers' compensation] settlement does not meet the 30-month and $250,000 thresholds, typically that individual will completely exhaust his/her settlement by the time Medicare eligibility is reached. Also, according to various members of the [workers' compensation] community, most settlements for these individuals are in the range of $10,000 to $50,000. Therefore, the amount of money in the settlement that is actually being provided for an individual's medical care normally will be appropriately exhausted before the individual becomes a Medicare beneficiary." CMS Memo May 23, 2003 (Question 3).

- For settlements, still consider a MSA if future medical treatment is needed, or at least indicate with individuals with a reasonable expectation which do not quite meet the $250,000 threshold, in settlement documents that a portion of the money is being paid for future medical expenses.
- CMS will not review and approve though.

- If claimant is *not* a Medicare beneficiary and does *not* have reasonable expectation of entitlement within 30 months, Medicare does not have an interest in that settlement, even if future medical benefits are closed.

- Medicare will **NOT** issue opinion letters concerning the need or not for a MSA.
- Therefore, if case does not meet the review thresholds, should not submit it to CMS.

Determining Amount for MSA

- MSA accounts consist only of money to cover expenses that Medicare would otherwise pay
- Allocation reports helpful to determine amount CMS will likely require for MSA.
- Allocation amount based on workers' compensation fee schedule or actual/usual and customary charges, whichever is appropriate in the state

- When there is a dispute among treating physicians concerning future treatment needs, CMS will almost always require money to cover the most comprehensive treatment recommended.
- Questions concerning causation do not alter CMS' requirement for money to cover disputed injuries. Unless prior judicial determination, CMS requires money in MSA account even if causation is disputed.

- Claimants may not allege an injury, receive money for that injury and make Medicare pay for medical treatment related thereto.

- CMS will not approve a settlement in which a claimant "promise[s] not to bill Medicare for certain services in lieu of including those services in a Medicare Set-aside arrangement" (CMS Memo April 22, 2003)

- Bottom line: CMS will not allow a reduced or compromised Medicare Set-aside amount. (CMS Memo July 11, 2005)
- The MSA account must have adequate funds to pay for ALL likely future medical treatment

"Guaranteed" Allocation Reports

- Usually very costly and problematic
- Over-allocation for medical treatment
- Most expensive or complex treatment options included
- Often increase frequency and duration of services over what CMS will likely require
- Often include unnecessary money for non-specific services or complications
- Additional amounts charged for the "guarantee"
- Responsibility for paying on a guarantee is often limited, such as not paying "if the increase in price is due to a change in CMS policy," which is quite often the reason for CMS requesting more money for MSA

Prescription Medications

- Money must be included in MSA accounts for prescription medications
- CMS will review and independently price for medical treatment expenses, however, CMS simply NOTES the amount submitted for prescriptions
- There is an argument that CMS left open a door to pursue parties who price prescription medications unrealistically low

- CMS does not care about Pharmacy Reviews or pharmacist's opinions concerning medications.
- CMS looks at physicians actual recommendations and prescriptions claimant is actually receiving.

Settlement of Cases Prior to Obtaining CMS Approval

- No amount included in settlement documents is binding on CMS unless CMS approves that amount
- Parties must provide CMS with documentation that the account has been funded ***as CMS approved***, in order to finalize the CMS process and ensure no future problems

Funding Medicare Set-aside Accounts

- Lump sum
  - CMS stated that "lump sums…present less of a problem to monitor than structured arrangements."
- Annuity
  - Annuity is usually substantially cheaper than lump sum
  - If MSA account will be funded with an annuity, must submit to CMS accordingly. Parties not allowed to change mind about funding of account.

Administration

- Self-administration
  - Permissible as long as claimant is legally competent
- Custodian Administration
  - Custodian may be relative, guardian, conservator, or an entity which has been paid to administer the account

Administration Requirements

- Regardless of the method of administration, the same accounting requirements must be followed.
- Annual attestation documents must be filed
- Account will be monitored by CMS contractor to ensure funds spent properly

Obtaining CMS Approval of Set-aside Amount

- Files submitted to Workers' Compensation Review Center (WCRC) for recommendation to CMS Regional Office (RO) as to adequacy of amount submitted
- RO actually issues "determination letter"
- Usually takes a few months to obtain approval

- No appeals process if CMS rejects the amount of the initial proposal
- Obvious mistakes, such as mathematical errors, may be corrected by contacting the Regional Office

State Court, Board or Commission Approved Settlements

- Medicare will generally honor decisions but only if issued after a hearing on the merits of a case by a court of competent jurisdiction.
- Medicare will not simply accept documents approved by any such body if they merely incorporate the parties' settlement agreement
- Medicare will not accept a settlement agreement, even if approved in the state, if it does not adequately address Medicare's interests

Settling a Case Prior to CMS Approval

- If parties do not want to wait for CMS approval because they do not want to continue paying indemnity benefits, CMS recommends closing indemnity and leaving medicals open while awaiting CMS approval
  - Unreasonable in most cases
- Parties may proceed with settlement, however, unless CMS approves the MSA amount indicated in the settlement documents, CMS' interests will not be deemed protected

Coverage in Addition to Medicare

- Even though claimant may have a group health plan or be covered by VA or other benefits, MSAs are still required, in appropriate cases.
- Claimant could lose entitlement to other plan or decide not to utilize the other coverage.

Loss of Medicare Entitlement

- Even if a claimant loses Medicare entitlement, funds may not be released from account. They must continue to be used to cover medical expenses Medicare would otherwise cover.

Workers' Comp and Third Party Cases

- MSA is required in cases involving a workers' comp claim and a third party claim if the workers' comp carrier is being relieved of the obligation to pay future medical expenses

Liability Only Cases

- Key difference between workers' comp and liability cases
  - In workers' comp cases, state law usually mandates lifetime payment of all future medical expenses related to a work injury
  - In liability cases, responsibility to pay future medical expenses is a product of a settlement agreement itself, not a requirement of state law

- CMS does not ***require*** MSAs or prior approval of settlements in liability cases
- Using a MSA for Medicare beneficiaries and obtaining CMS review and approval, if available, is the best way to guarantee no future problems with Medicare

- Regional Offices are vested with substantial discretion regarding review of liability cases involving Medicare beneficiaries
  - Some will review and some will not. No standard guidelines to determine if RO will review.
- No formal CMS review process for liability cases

- If settling a liability case with a claimant ***who is a Medicare beneficiary likely to need future medical care*** and the settlement agreement includes payment of money for such future treatment,
  - Parties may designate in the Release a portion of the settlement money to cover such expenses OR
  - A MSA may be used.
- If parties are not able to determine reasonable amount, allocation report may be helpful.

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